

# EXHIBIT A

## NOTICE OF DISPUTE

Michigan Department of Consumer & Industry Services  
 Bureau of Workers' Disability Compensation  
 P O Box 30016, Lansing, MI 48909

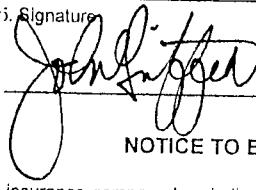
1. Social Security No.	2. Date of Injury	3. Employee Name (Last, First, MI) SINGLETON, CHRISTINE J.		
4. Employee Address (Street No. and Name) 940 HARRISON		5. City	6. State	7. Zip Code
LINCOLN PARK MI 48146				
8. Employer Name United Parcel Services				
9. Federal ID No. 36-2407381				
10. Employer Street Address 25600 NORTHLINE ROAD		11. City	12. State	13. Zip Code
TAYLOR MI WAYNE				
14. Carrier or Self-Insured Name Liberty Mutual Insurance				
15. NAIC or Self-Insured No. 23043-111				
16. Zip Code 46207				
17. Service Company/TPA Name (if applicable)				
18. Service Co./TPA ID No.				
19. Service Co./TPA ID No.				
20. Claim or File No. 471-694863		21. County of Injury	22. County Code (if known)	
WAYNE				
23. Reason For Dispute				

- A.  Injury not work related
- B.  Medical treatment not related to injury
- C.  Further investigation required (please specify below)
- D.  Additional information required from employee (please specify below)
- E.  Vocational rehabilitation dispute only (please specify below)
- F.  Other (please specify below)

PER THE INDEPENDENT MEDICAL EXAM OF DR. PAUL DROUILLARD DATED 12/28/07 THE EMPLOYEE IS CAPABLE OF RETURN TO WORK WITH NO RESTRICTIONS AT UPS. THEREFORE, BENEFITS HAVE BEEN TERMINATED.

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.	Authority: Workers' Disability Compensation Act, R408.33(1)
	Completion: Mandatory
	Penalty: Workers' Disability Compensation Act, 418.631; 418.631; R408.33

This is to certify that a copy of this form has been mailed or given to the injured employee.

24. Preparer Name (Please print)	25. Signature	26. Telephone No.	27. Date
John Griffith		(800) 752-5832	01/09/2008

## NOTICE TO EMPLOYEE

By filling this form, your employer or its workers' compensation insurance company has indicated to the Bureau of Workers' Disability Compensation that it has a question or a dispute concerning the possible workers' compensation benefits to which you may be entitled. You may or may not agree with the position taken by the employer or insurance company.

I feel that you are not receiving the benefits to which you are entitled, you should discuss this with your employer or a representative of its insurance company. If you have already done that or you are not satisfied with the discussion, you may request an informal conference or file a formal application for mediation or hearing. You can obtain the appropriate forms or more information by contacting the Bureau of Workers' Disability Compensation at one of the offices listed below.

DETROIT  
 State of Michigan Plaza Building  
 1200 Sixth Street, 12th Floor  
 (313) 286-2770

FLINT  
 Bristol West Center  
 G-1388 West Bristol Road  
 (810) 760-2819

KALAMAZOO  
 4203 West Main  
 (616) 337-3630

PONTIAC  
 NBD Building  
 28 N. Saginaw, Suite 1310  
 (810) 334-2497

ESCANABA  
 State Office Building  
 105 Ludington  
 (906) 786-2081

GRAND RAPIDS  
 2942 Fuller Street N.E.  
 (616) 447-2671

LANSING AREA  
 2501 Woodlake Circle, Okemos  
 (517) 241-9393

MOUNT CLEMENS  
 10th Floor, Old Country Building  
 10 N. Main  
 (810) 463-6577

SAGINAW  
 State Office Building  
 411-K East Genesee  
 (517) 758-1768

TDD In Lansing  
 (517) 322-5987

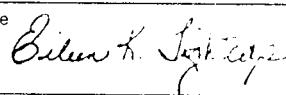
**NOTICE OF DISPUTE**  
 Michigan Department of Consumer & Industry Services  
 Bureau of Workers' Disability Compensation  
 P O Box 30016, Lansing, MI 48909

1. Social Security No.	2. Date of Injury	3. Employee Name (Last, First, MI) Conforto, Janet M		
4. Employee Address (Street No. and Name)	5. City	6. State	7. Zip Code	
14735 Park	Livonia	MI	48154	
8. Employer Name United Parcel Service			9. Federal ID No. 36-2407381	
10. Employer Street Address 29855 Schoolcraft Rd		11. City Livonia	12. State MI	13. Zip Code 48150
14. Carrier or Self-Insured Name Liberty Mutual Insurance Company			15. NAIC or Self-Insured No. 230430111	16. Zip Code 46032
17. Service Company/TPA Name (if applicable)			18. Service Co./TPA ID No.	19. Zip Code
20. Claim or File No. WC 471-633980		21. County of Injury		22. County Code (if known)
23. Reason For Dispute				
A. <input type="checkbox"/> Injury not work related B. <input type="checkbox"/> Medical treatment not related to injury C. <input type="checkbox"/> Further investigation required (please specify below) D. <input type="checkbox"/> Additional information required from employee (please specify below) E. <input type="checkbox"/> Vocational rehabilitation (dispute only (please specify below)) F. <input checked="" type="checkbox"/> Other (please specify below)				
Cutting off wage loss benefits only. Per our ME, she is full duty (09-11-06)				

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 Completion: Mandatory  
 Penalty: Workers' Disability Compensation Act, 418.631; 418.631; R408.33

This is to certify that a copy of this form has been mailed or given to the injured employee.

24. Preparer Name (Please print)	25. Signature	26. Telephone No.	27. Date
Eileen K Lightcap		(800) 752-5832	09/11/2006

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**FLINT**  
 Bristol West Center  
 G-1388 West Bristol Road  
 (810) 761-2618

**KALAMAZOO**  
 4203 West Main  
 (616) 337-3630

**PONTIAC**  
 NBD Building  
 28 N. Saginaw, Suite 1310  
 (810) 334-2497

**ESCANABA**  
 State Office Building  
 305 Ludington  
 (906) 786-2081

**GRAND RAPIDS**  
 2942 Fuller Street N.E.  
 (616) 441-2670

**LANSING AREA**  
 2501 Woodlake Circle, Okemos  
 (517) 241-9393

**SAGINAW**  
 State Office Building  
 411-K East Grand  
 (517) 758-1768

**MOUNT CLEMENS**  
 10th Floor, Old Country Building  
 10 N. Main  
 (810) 463-6577

**RECEIVED**  
 TDD in Lansing  
 (517) 322-5987  
 SEP 18 2006

**NOTICE OF DISPUTE**

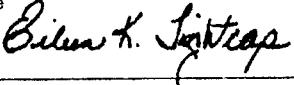
Michigan Department of Consumer & Industry Services  
 Bureau of Workers' Disability Compensation  
 P O Box 30016, Lansing, MI 48909

1. Social Security No.	2. Date of Injury 11/01/2005	3. Employee Name (Last, First, MI) Didonato, Daniel P		
4. Employee Address (Street No. and Name) 18267 Mac Arthur		5. City Redford	6. State MI	7. Zip Code 48240
8. Employer Name United Parcel Service				9. Federal ID No. 36-2407381
10. Employer Street Address 29855 Schoolcraft Rd		11. City Livonia	12. State MI	13. Zip Code 48150
14. Carrier or Self-Insured Name Liberty Mutual Insurance Company			15. NAIC or Self-Insured No. 230430111	16. Zip Code 46032
17. Service Company/TPA Name (if applicable)			18. Service Co./TPA ID No.	19. Zip Code
20. Claim or File No. WC 471-634931		21. County of Injury		22. County Code (if known)
23. Reason For Dispute				
A. <input checked="" type="checkbox"/> Injury not work related				
B. <input type="checkbox"/> Medical treatment not related to injury				
C. <input type="checkbox"/> Further investigation required (please specify below)				
D. <input type="checkbox"/> Additional information required from employee (please specify below)				
E. <input type="checkbox"/> Vocational rehabilitation dispute only (please specify below)				
F. <input type="checkbox"/> Other (please specify below)				
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 Completion: Mandatory  
 Penalty: Workers' Disability Compensation Act, 418.631; 418.631; R408.33

This is to certify that a copy of this form has been mailed or given to the injured employee.

24. Preparer Name (Please print) Eileen K Lightcap	25. Signature 	26. Telephone No. (800) 752-5832	27. Date 03/30/2006
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 Okemos  
 (517) 241-9393

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**TDD in Lansing**  
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**NOTICE OF DISPUTE**

Michigan Department of Consumer & Industry Services  
 Bureau of Workers' Disability Compensation  
 P O Box 30016, Lansing, MI 48909

1. Social Security No. 3 71 2446	2. Date of Injury 06/16/2005	3. Employee Name (Last, First, MI) MILLER, JOHN E.		
4. Employee Address (Street No. and Name) 10555 N COUNTY LINE HWY		5. City MILAN	6. State MI	7. Zip Code 48160
8. Employer Name United Parcel Services				
10. Employer Street Address 540 SOUTH MANSFIELD ST.		11. City YPSILANTI	12. State MI	13. Zip Code 48197
14. Carrier or Self-Insured Name Liberty Mutual Insurance		15. NAIC or Self-Insured No. 23043-111		
17. Service Company/TPA Name (if applicable)		18. Service Co./TPA ID No.		
20. Claim or File No. 471-609205		21. County of Injury WASHTENAW		
22. County Code (if known)				

## 23. Reason For Dispute

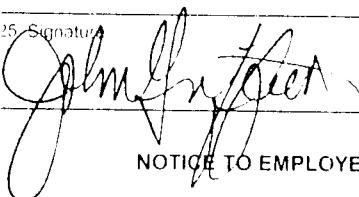
- A.  Injury not work related
- B.  Medical treatment not related to injury
- C.  Further investigation required (please specify below)
- D.  Additional information required from employee (please specify below)
- E.  Vocational rehabilitation dispute only (please specify below)
- F.  Other (please specify below)

PER THE IME OF DR. DROUILLARD THE EMPLOYEE IS NO LONGER DISABLED FROM HIS JOB AT UPS AND MAY RETURN TO UNRESTRICTED DUTY. THEREFORE, BENEFITS HAVE BEEN SUSPENDED BASED ON THIS EXAMINATION.

**Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.**

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 Completion: Mandatory  
 Penalty: Workers' Disability Compensation Act, 418.631; 418.631; R408.33

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24. Preparer Name (Please print) John Griffith	25. Signature 	26. Telephone No (800) 752-5832	27. Date 10/19/2005
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